POLICY

It is the policy of Detroit Wayne Mental Health Authority (DWMHA) that all DWMHA treatment providers monitor a client's ability to pay for treatment. Each provider must complete a client Determination of Eligibility Worksheet on each DWMHA client from all funding sources.

DWMHA shall assure that 12 month availability of services, for any subcontracted Substance Use Disorder (SUD) treatment or prevention service, each subcontractor maintains service availability throughout the fiscal year for persons who do not have the ability to pay.

PURPOSE

DWMHA’s SUD and Utilization Management (UM) Departments are required to manage SUD authorizations for services and its expenditures in light of known available resources in such a manner as to avoid the need for imposing arbitrary caps on authorizations or spending. “Arbitrary caps” are those that are not adjusted according to individualized determinations of the needs of clients. This requirement is consistent with Medical Necessity Criterion.

APPLICATION

This policy applies to all SUD consumers and providers. SUD providers must check consumer's ability to pay no matter the funding source. This information must be kept in the provider's case record at all times.

KEY WORDS

STANDARDS

1. Financial information to determine ability to pay must be reviewed at least every six months, or at a change in an individual's financial status.

2. Third party insurance must be utilized to its full extent.
   a. Once insurance benefits are exhausted, if medically necessary services are not fully covered by the third party insurance, or if the co-pay or deductible amount is greater than the person's ability to pay, Block Grant funds may be applied.
   b. MDHHS - administered funds must be applied after exhausting all 1st and 3rd party payments.
3. No DWMHA client will be denied treatment services because of inability to pay or meet his/her co-pay. The SUD Department will review situations where a client reports an inability to pay his/her co-pay, and make determinations on a case-by-case basis. See DWMHA’s Client Co-Pay Policy.

4. All treatment providers will use the attached Determination of Eligibility Worksheet and a copy will remain in the client's case record.

5. It is the provider's responsibility to notify the UM Dept. if there has been a significant change in the client's financial status.

QUALITY ASSURANCE/IMPROVEMENT

The Authority shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

This contractual obligation will be monitored on annual site visits conducted by DWMHA staff or its designee.

The quality improvement programs of MCPNs, their subcontractors and direct contractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

Authority staff, MCPNs, contractors and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

Michigan Department of Health and Human Services
Michigan Office of Recovery Oriented Systems of Care

RELATED POLICIES

1. Client Co-Pay

RELATED DEPARTMENTS

1. Compliance
2. Customer Service
3. Integrated Health Care
4. Legal
5. Managed Care Operations
6. Management & Budget
7. Quality Improvement
8. Recipient Rights
EXTERNAL

EXHIBIT(S)

1. DWMHA Determination of Eligibility Worksheet

Attachments: SUD Ability To Pay Policy exhibit.pdf

Approval Signatures

<table>
<thead>
<tr>
<th>Approver</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeff Delay: Chief Operating Officer [AS]</td>
<td>03/2016</td>
</tr>
<tr>
<td>Allison Smith: Project Manager, PMP</td>
<td>03/2016</td>
</tr>
<tr>
<td>Darlene Owens: Director, Substance Use Disorders, Initiatives</td>
<td>03/2016</td>
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<tr>
<td>Carmen McIntyre: Chief Medical Officer</td>
<td>03/2016</td>
</tr>
</tbody>
</table>
DETROIT WAYNE MENTAL HEALTH AUTHORITY (DWMHA)
DETERMINATION OF ELIGIBILITY WORKSHEET

Program Name: ________________________________

1. INCOME
(Use Annual Income figures, rounded to the nearest whole dollar)

   Client's Earned Income: 1. $_______________

   Add (where applicable):

   Spouse (cohabitant) Income: 2. $_______________

   (If minor living with parents)
   Father/Guardian Income: 3. $_______________

   Mother/Guardian Income: 4. $_______________

   TOTAL EARNED INCOME: 5. $_______________
   (Add lines 1 thru 4)

   ADD: Additions to Income:
   (i.e., SSI, SSDI, Unemployment, Workers Compensation, Child Support)
   Specify:
   6a. $_______________
   6b. $_______________

   SUBTOTAL: 7. $_______________
   (Add lines 5 thru 6b)

   DEDUCT: Child Support paid for
   (Children not claimed as dependents)
   On Income Tax Forms 8. $_______________

   Adjusted Annual Income:
   (Line 7 minus line 8) 9. $_______________

2. DEPENDENTS:

   Number of children living in the home: 10. _______________
   (Include client if minor)

   (Number of children not living in the home)
   but claimed as dependents on Income Tax Forms: 11. _______________

   TOTAL DEPENDENTS: 12. _______________
   (Add Lines 10 & 11)
### 3. ABILITY TO PAY:

<table>
<thead>
<tr>
<th>Description</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost per unit of service (treatment day, individual, group, etc.)</td>
<td>13</td>
</tr>
<tr>
<td>% Rate Obligation to pay: (on Federal Fee Scale)</td>
<td>14</td>
</tr>
<tr>
<td>Client's Cash Obligation: (unit cost x % rate)</td>
<td>15</td>
</tr>
<tr>
<td>If 15 is less than $1.00 enter $1.00 on line 16</td>
<td>16</td>
</tr>
<tr>
<td>Expected number of treatment Units:</td>
<td>17</td>
</tr>
<tr>
<td>Total Client Obligation: (16 x 17)</td>
<td>18</td>
</tr>
</tbody>
</table>

This is a preliminary agreement. The provider may revise this agreement, if changes occur in the client's financial status.

The undersigned client certifies the above income and family information to be true and understands that providing false information constitutes fraud.

The client is responsible for paying the client portion of the treatment cost as shown on line 18.

The identified client obligation may be waived by the AMS if the provider provides justification that the identified amount will cause the client undue financial hardship. The AMS will review all pertinent information. See attached Waiver of Client Financial Ability To Pay For services.

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Client Signature: ___________________________ Date: ___________________________

Staff Signature: ___________________________ Date: ___________________________

Witness Signature: ___________________________ Date: ___________________________

PROVIDER NAME: ___________________________
DECLARATION OF INCOME AND SERVICE COST
All questions should be answered; those not applicable must be marked with NA.

I understand that a portion of the cost of services provided to me is being subsidized by public funds. As required by eligibility guidelines, I hereby certify that my personal and household income for the past 12 months was $___________.

I further understand and agree that this amount and the dates that I receive service may be subject to further verification by DWMHA or its treatment contractors. Additionally, this information will be reviewed every 90 days after admission to treatment.

I understand that the co-payment portion of my service cost is my responsibility to pay.

Print Client Name ___________________________ Date ___________________________

Client Signature ___________________________

Print Witness Signature ___________________________ Date ___________________________

Witness Signature ___________________________
WAIVER OF CLIENT FINANCIAL ABILITY TO PAY FOR SERVICES

DATE: ____________

CLIENT NAME: _______________________

CLIENT DATE OF BIRTH: ________________

I am requesting that the ability to pay criteria established for this client be waived for the following reasons:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Client Signature ___________________ Date ____________

Program Staff Signature ______________ Date ____________